IDAHO DEPARTMENT OF
HEALTH & WELFARE

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RICHARD M. ARMSTRONG – Director

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September 18, 2006

Lori Bentzler, Administrator
Bridgeview Estates
1828 Bridgeview Blvd
Twin Falls, ID 83301

Provider #: 135113

Dear Ms. Bentzler:

On **August 31, 2006**, a Complaint Investigation was conducted at Bridgeview Estates. Marcia Key, R.N. and Lorna Bouse, L.S.W. conducted the complaint investigation. A total of ten survey hours were required to complete this investigation. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00001755

ALLEGATION #1:

The complainant stated an identified resident consistently had to wait over two hours to get her call light answered. This occurred on all shifts. The resident frequently soiled herself because her call light was not answered.

FINDINGS:

The identified resident was admitted to the facility on August 3 and discharged August 19, 2006.

An immediate tour of the facility was conducted, with special focus on the Medicare hall where the resident had resided. Random residents and family members were interviewed. There were no identified concerns regarding call lights not being answered in a timely manner. No one confirmed it took two hours to get call lights answered. The resident council minutes were reviewed from June 2006 through August 2006. There were no identified concerns regarding call lights. The resident council minutes for June documented, "Nursing care is excellent." The minutes for July documented, "Response to the call lights continues to be good."

Throughout the investigation random observations were conducted. Call lights were answered within two to five minutes.

CONCLUSIONS:
Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

The complainant stated the facility refused to utilize a mechanical lift for transfers and insisted that a slide board be used. The complainant stated the resident complained about the difficultly in using the slide board and sustained a skin tear to her labia area as a result. She was pinched and it caused blood blisters.

The complainant stated the facility did not use two staff members to assist the resident with transferring. The facility should have used two staff members due to the resident's size and injuries. As a result, an identified staff member (first name only identified by the complainant), caused additional injury to the resident's left ankle, she thinks. Her leg twisted in the cast and was re-injured. The treating physician documented this injury in the resident's record.

FINDINGS:

The identified resident was assessed shortly after her admission to the facility by a nurse, and the therapy staff. It was determined the resident would benefit from the use of the slide board for bed to chair transfers so she could participate in the transfers. This was discussed and agreed upon by the resident. The care plan and interdisciplinary notes identified the transfers could safely by performed with the assist of one or two staff members. The record documented the resident often refused to use the slide board despite safety education by the staff.

The interdisciplinary notes documented on August 7, 2006, that the resident told a physical therapist the slide board caused blood blisters on her labia. After the resident's lunch the same day, the treatment nurse examined her and found no blood blisters on the labia.

The facility's incident and accident reports were reviewed. There was one report, dated August 11, 2006, which identified the resident reported to staff that her inner thigh got pinched on the loose toilet seat. She was examined and found to have a small red bruise to the site. There were no other injuries documented.

There was no incident and accident report identifying a staff member causing an injury to the resident's ankle. There was no staff employed in the facility by the first name identified in the complaint.

There were no physician's progress notes in the resident's record. Two physician's progress notes

were obtained from his office. There was no documented evidence the resident's ankle had been re-injured. The first visit on August 4, 2006, documented the right plaster splint was too long, so this was trimmed. The second physician visit on August 10, 2006, documented the casts were removed and she was fitted with ankle walking boots.

CONCLUSIONS:
Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

The complainant stated the facility does not have enough staff.

FINDINGS:

The complainant did not specify the days the facility was short staffed.

The facility's staffing schedule was reviewed from Friday, August 4, 2006 through Saturday, August 12, 2006. The facility met the required 2.4 nursing hours for each 24 hour period reviewed. On all but three days, the staffing was at least 3.4 nursing hours.

The resident council minutes from June through August 2006 did not identify issues with insufficient staff.

Random residents and family members were interviewed. There were no identified concerns regarding insufficient staff to meet the needs of the residents.

CONCLUSIONS:
Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #4:

The complainant stated the resident complained about the difficultly in using the slide board and sustained a skin tear to her labia area as a result. The complainant stated the resident informed the staff of the skin tear; however, this was not assessed for over 24 hours.

One night the resident had angina. She told the nurse but was informed that her signs and symptoms were not angina. There was no nitroglycerin medication, and the nurse would not call for an order because the signs and symptoms did not match angina. The nurse did give her pain medication which helped the pain but the pressure was still present. The nurse finally got an order for the nitroglycerin medication.

The next day, she had angina again and had to argue with the staff again for nitroglycerin patches. They finally did find them.

FINDINGS:

The interdisciplinary notes documented the resident told a physical therapist the slide board caused blood blisters on her labia. The treatment nurse examined her that afternoon and found no blood blisters on the resident's labia.

The nurses' notes documented the first two times the resident told the staff she was experiencing chest pain the physician was notified timely. Orders were received for the nitroglycerin medication and the resident received the medication. There were two occasions when the staff told the resident she needed to be transported to the emergency room for evaluation of the chest pain. According to the documentation, the resident immediately informed the staff she was feeling better and did not need to go to the emergency room.

CONCLUSIONS:
Unsubstantiated. Lack of sufficient evidence.

As none of the complaints were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,

Marcia Key

MARCIA KEY, R.N.
Health Facility Surveyor
Long Term Care

MK/dmj

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Dear Ms. Bentzler:

On **August 31, 2006**, a Complaint Investigation was conducted at Bridgeview Estates. Marcia Key, R.N. and Lorna Bouse, L.S.W. conducted the complaint investigation. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00001790

ALLEGATION #1:

The complainant stated an identified resident fractured his hip and had a surgical repair. The resident was transferred for after care to the facility on June 23, 2006.

The complainant was told the resident would be on a Medicare hall and receive acute care skilled nursing. The first thing the complainant noticed was there were only two aides and a nurse, who stayed at the medication cart, to take care of at least 36 people on the hall. There was not enough staff. The family only kept the resident in the facility, with a private duty nurse at night, until June 26, and then took him home.

FINDINGS:

The facility records for staffing were reviewed for the time period the complainant stated there was inadequate staffing. The staffing numbers were all above the state's daily requirement. The administrator was interviewed regarding staffing numbers. The administrator stated that staffing had been constant for quite some time and that the facility staffs above the state's required

numbers.

Several residents who were interviewed did not indicate staffing was a problem. They acknowledged there were busy times in the day (meal time, bed time, etc.) However, no one indicated they had poor outcomes related to more staff demand when there was an occasional higher resident need. Resident council minutes were reviewed. Again the records indicated that residents did not feel staff was not meeting their needs.

The resident's closed record was reviewed. The admit nurse's progress note documented, "While at the hospital did have a sitter and the (a family member) wants to continue sitter here and is paying for one." However, the discharge orders from the hospital documented "Do not need sitter according to MD." An admission's progress note also documented the resident had been placed close to the nurses' station for increased observation.

CONCLUSIONS:
Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

The complainant noticed the resident's room was dirty. There was a bad odor. The bathroom was "grungy."

FINDINGS:

The surveyors conducted a tour of the facility after entering unannounced for the complaint investigation. The rooms or bathrooms did not have any odors. There was some housekeeping in progress at the time of the tour. However, rooms that had not yet been cleaned did not have an odor and appeared clean and orderly. Interviewable residents were asked during the tour if the facility kept their rooms clean and in order. They stated that the facility was keeping their space clean and they had no complaints.

CONCLUSIONS:
Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

There was no linen available. When linen was requested, the complainant never got any, and was told she could not go and get it for the resident as it was locked up.

The resident had a roommate. The roommate had a wash cloth on a hook in the bathroom with a note pinned to it telling staff not to take it. When the complainant asked the roommate why, he said he needed to keep it because they would not bring another one.

FINDINGS:

After the two surveyors entered the facility, a tour was initiated immediately. The surveyors were not accompanied by staff. Interviewable residents, in their rooms, were asked if they were able to get linen when they needed it. None of the residents had an issue with linen being provided. A family member was visiting a resident and was asked if linen was available. The family member said he visited at least five times a week. He indicated the resident could not do any care independently and that the facility brought linen in when they provided the care. There was however, clean linen in the bathroom. One male resident was in his wheelchair self propelling up the hall. He had a stack of towels on his lap. When he was asked how he got all the linen, he stated he asked staff and they gave it to him.

Most of the residents' bathrooms on each unit were observed and almost all contained clean linens. One bathroom did not have any linen. When the resident was asked why he did not have linen he stated, "I don't need it. I can't use it, staff does all my care." He said if he wanted it, he would ask. The resident was in the room by himself and did not have a roommate.

CONCLUSIONS:
Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #4:

The resident's roommate indicated to the complainant that he did not complain to staff about the lack of linen as the staff would make things harder on him if he did. The complainant alleged the roommate was afraid to say anything because he feared retribution.

FINDINGS:

The survey team was able to determine the identity of the roommate. However, the roommate had been discharged from the facility. The team was unable to interview him. The surveyors could not substantiate that the roommate was afraid to complain because of fear of retribution.

CONCLUSIONS:
Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #5:

The complainant stated she saw staff pouring urine from the urinal into the resident's sink and felt it was unsanitary and contributing to odor.

FINDINGS:

The surveyors spent a minimum of five hours investigating the complaint. The pouring of urine

into resident sinks was not observed during the complaint investigation.

CONCLUSIONS:
Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #6:

The complainant stated the resident's physician discharged the resident from the hospital with strict orders for non-weight bearing as his hip would shatter if he stood on it too soon. The first night the resident was in the facility, two female staff tried to get him up to use the bathroom. A private duty nurse, that the family had hired, stopped them from allowing him to bear weight.

FINDINGS:

The surveyor reviewed the closed record. A physician's discharge order from the hospital, dated June 23, 2006, directed, "Assistive devices FWW (front wheel walker), Weight-bearing limitations PWB (partial weight bearing)." The resident's closed record did not contain documentation that facility staff had tried to get the resident to stand and go to the bathroom. Incident reports were also reviewed to determine if such an incident had occurred. There was no documentation that a private duty nurse had intervened to stop the resident from bearing weight on his hip.

CONCLUSIONS:
Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #7:

On the first day of the resident's stay the complainant stated the resident became restless and uncomfortable. The family requested pain medication for him. The time was 4:37 p.m. He did not get anything for pain until 8:00 p.m. It had been a total of eight hours since he last had medication for pain. The nurse blamed it on the pharmacy indicating they had not sent the medication. The facility had assured the family prior to admission that someone would be assessing him for pain frequently and medicating him as needed.

FINDINGS:

The hospital physician's discharge orders documented, "Pain maintenance... relieved by: Darvocet- use sparingly." The copies of medication administration records from the hospital, dated June 22 and 23, 2006, were reviewed. There was no record of pain medication administered on either day. The facility's records documented the resident was admitted on June 23, at 4:00 p.m. The nurses' progress note further documented, "...0 c/o (No complaints of) pain at this time..." The medication administration records for the facility indicated the resident had an order for pain medication which could be administered every four hours as needed for pain.

The resident received pain medication the evening of admission at 7:00 p.m., when it was observed he was in pain. This was three hours after he arrived at the facility. An initial assessment of the resident indicated he could make his needs known.

The Director of Nursing was interviewed regarding the availability of medications. He indicated if a medication needed to be ordered through the pharmacy it could take one hour or a bit longer to get the medication. He asked a nurse if the prescribed medication had been available for the resident. The nurse indicated that particular pain medication was stored and available in the computerized patient medication distribution system at all times. (It was available upon request).

CONCLUSIONS:
Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #8:

The resident was admitted to the facility with oxygen. After four to five hours it was discovered by the family that the oxygen tubing had never been hooked up to the concentrator. The resident suffered no ill effects.

The facility would not allow the resident to use side rails. They indicated a pressure alarm would be placed on his bed. The complainant asked how long it would take them to answer the alarm. The complainant was assured it was a specialized alarm that would be answered immediately. Once when the family was in the room and sat on the bed the alarm activated at 7:34 p.m. No one came in the room to check the resident until 7:49 p.m.

The complainant told the nurses that the resident had macular degeneration and dementia. He needed assistance to eat but the staff would just drop his tray off and say, "If you need anything use your call light." The complainant said he could not see his call light and has short term memory issues and never would remember what they told him. He also needed some help to eat.

FINDINGS:

The resident's admission orders directed oxygen at one liter per minute by nasal cannula as needed only. The hospital nurses' progress notes documented the resident was placed on oxygen in the hospital for oxygen saturation levels in the low 80% range. In the facility, saturation level was 87% once on June 23 and later that day at 95%. For the other two days his saturation levels did not fall below 93%. No documentation indicated that his oxygen tube was not hooked to his concentrator.

Residents were observed who were receiving oxygen in their rooms. All were appropriately connected to the oxygen concentrators.

Documentation in the resident's record did indicate that alarms were recommended and in use.

There was no documentation to substantiate that the nursing staff had not answered his alarm in a timely manner. The survey team timed the answering of call lights and how fast staff answered alarms. The times ranged from 1 to 3 minutes. The administrator was observed during a conversation with surveyors to respond to an alarm.

It was verified in the resident's closed record that he had macular degeneration and dementia. It could not be determined during the investigation that he was not offered assistance to eat or told to use his call light. However, residents who received trays in their rooms were observed. There was no resident who could not eat independently that received a tray in their room.

CONCLUSIONS:
Unsubstantiated. Lack of sufficient evidence.

As none of the complaints were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,

MARCIA KEY, R.N.
Health Facility Surveyor
Long Term Care

MK/dmj